Virginia Department of Health
REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

To Whom It May Concern:

The above named individual has been evaluated by _____
(Name of health dept./facility)

Tuberculin Skin Test (TST)

Date given: _____ Date read: _____

Results: _____mm ___ Negative ___ Positive

The individual listed above has no symptoms compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Interferon Gamma Release Assay Alternative test for the tuberculin skin test (TST)

Date drawn _____ Time drawn _____

Result: ___Neg ___Pos ___Indeterminate ___Borderline

The individual listed above has no sympotms compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Chest X-Ray – No active disease

Date of Chest x-ray _____

___ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Chest X-Ray – Abnormal Report

Date of Chest x-ray _____

___ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____